Idaho Health Home State Plan Amendment Matrix: Summary Overview

This matrix outlines key program design features from health home State Plan Amendments (SPAs) approved by the Centers for Medicare & Medicaid Services (CMS) as of November 2012. For more information about health homes (HH), visit www.integratedcareresourcecenter.com.

Overview of Approved Health Home SPAs

STATE	TARGET POPULATION	HH PROVIDERS	ENROLLMENT	PAYMENT	GEOGRAPHIC AREA
IDAHO **SPA STATUS: FINAL SPA APPROVED (11/21/12)**	A chronic condition of SPMI or SED; Diabetes and asthma; or Have either diabetes or asthma and be at risk for another chronic condition.	Current Healthy Connections providers that meet set standards, including physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or any other current Health Connections providers.	Can self-refer or be referred by any service provider. Eligible beneficiaries will be automatically enrolled, with ability to opt-out.	Per-member-per-month (PMPM) payment for comprehensive care management services.	Statewide

STATE: IDAHO	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Beneficiaries with either a chronic condition of SPMI or SED; Diabetes and asthma; or those that have either diabetes or asthma and are determined at risk for another chronic condition. At risk factors include: a body mass index greater than 25, Dyslipidemia, tobacco use, hypertension, or diseases of the respiratory system.
Geographic Area	Statewide
Delivery Systems	HH PMPM payments will be made on top of the existing FFS payments within Idaho's primary care case management system
Enrollment	Can self-refer or be referred by any service provider. Eligible beneficiaries will be automatically enrolled, with ability to opt-out. To avoid duplication of services, qualifying members currently receiving Targeted Case Management (TCM) as a service will shift the delivery of this care to their HH practice.
Building Blocks	Building off Idaho's Medicaid primary care case management program, Healthy Connections.

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Designated Providers	Current Healthy Connections providers, including physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or any other current Health Connections providers. Must have the systems and infrastructure in place to provide HH services. See section below on provider standards and qualifications for further details. Designated providers may operate in coordination with health care professionals inside and outside of their practice as they feel it is necessary to meet the needs of any particular patient. Other health care professionals could include, but are not limited to a Registered Nurse, Medical Assistant, Dietician, Behavioral Health provider, etc.
Provider Standards/Qualifications	Under Idaho State's approach, designated providers are the central point for directing patient-centered care. Designated providers are accountable for reducing avoidable health care costs (specifically preventable hospital admissions/readmissions and avoidable ER visits), providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and mental health care through direct provision with appropriate service providers, of comprehensive, integrated services. Designated providers will be held accountable by providing documentation of HH processes (transition to NCQA PCMH recognition) that ensures suitable HH service delivery. Documentation can include, but is not limited to transformation assessments, clinical process and outcome measures, and care plans for each HH participant. Designated providers must be participating primary providers in Idaho's Primary Care Case Management program, Healthy Connections. The designated provider will: 1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services; 2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; 3. Coordinate and provide access to preventive and health promotion services, including prevention and management of mental illness; 4. Coordinate and provide access to mental health services; 5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care; 6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; 7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; 8. Coordinate and provide access to long-term care supports and services; 9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; 10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; 11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level; and 12. Become at least level one NCQA recognized by the end of year two after initiation.

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Payment Methodology	The payment methodology for HHs is in addition to the existing fee-for-service and is structured as follows: Idaho will center the PMPM around a team of healthcare professionals that consist of a primary care provider, registered nurse, behavioral health professional, clerical staff, and medical assistant. The healthcare team will provide comprehensive care management for each established chronic care patient that is empanelled to the team. This reimbursement model is designed to only fund HH functionalities that are not covered by any of the currently available Medicaid funding mechanisms. The coordination of care and Primary Care Provider Consultant duties often does not involve face-to-face interaction with HH patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Idaho's HH model includes significant support for the leadership and administrative functions that are required to transform a traditional primary care clinic service delivery system to the new data-driven, population focused, patient-centered HH requirements. Idaho anticipates the healthcare team will spend an additional 30 minutes per member per month on comprehensive care management for the services described in section 2703 of the ACA. The HH PMPM was derived using average salaries, to include benefits, for each staff member that will assist in the comprehensive care management within the HH team. Average pay/hour was taken from the Bureau of Labor Statistics as reported in the state of Idaho. Staff members were given a percentage that was focused on the additional comprehensive care Idaho anticipates each team member assisting towards the chronic care patient.
Definition of Comprehensive Care Management	A care plan will be developed based on the information obtained from a health risk assessment performed by the designated provider. The assessment will identify the enrollee's physical, behavioral, and social service needs. This will ensure the patient's needs are identified, documented and addressed. Idaho anticipates family members and other support involved in the patient's care to be identified and included in the plan and executed as requested by the patient. The care plan must also include outreach and activities which will support engaging the patient in their own care and promote continuity of care. The care plan will include periodic reassessment of the individual's needs, goals, and clearly identify the patient's progress towards meeting their goals. Changes in the care plan will be made based on changes in patient needs. The designated provider's comprehensive assessment and care plan may include, but are not limited to family/social/cultural characteristics, medical history, advanced care planning, communication needs, and a depression screening for adults and children. Designated providers will identify patients/families that might benefit from additional care management support. The care coordinator in each practice will work closely with the designated provider to develop reminders for needed tests (e.g. HGAlCs), track medical services provided out of the primary care clinic office, and streamline communication and coordination of the comprehensive care needs of each patient. Comprehensive care management functions can include, but are not limited to: Conducts pre-visit preparations, collaborates with the patient/family to develop an individual care plan (including treatment goals that are reviewed and updated at each relevant visit), gives the patient/family a written care plan, assesses and addresses barriers when the patient has not met treatment goals, and gives the patient/family a clinical summary at each relevant visit. The care coordinator in each HH will track all referrals to ensure coordination of care between service providers. Designated providers will be responsible for obtaining and reviewing follow-up reports from medical and mental health specialists regarding services provided outside the HH.

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Definition of Care Coordination	Patients will choose and be assigned to a designated provider to increase continuity, and to ensure individual responsibility for care coordination functions. A person-centered plan will be developed based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable, and information on ways the patient participates in this care coordination, including home and community based services(HCBS). Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, demonstrating a process for consistently obtaining patient discharge summaries from the hospital and emergency departments, following up to obtain a specialist's reports, and direct collaboration or co-management of patients with mental health or substance abuse diagnoses. Under the direction of the designated provider, the care coordinator will help facilitate the patient's care needs. The coordinator should have knowledge and experience in the healthcare setting.				
Definition of Health Promotion	A designated provider will be required to actively seek to engage patients in their care by phone, letter, HIT and community outreach. Each of these outreach and engagement functions will include all aspects of comprehensive care management, care coordination, and referrals to community and social support services. All of the activities are built around the notion of relationships to care that address all of the clinical and non-clinical care needs of an individual including health promotion. The designated provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the health care professionals. The designated provider will promote evidence based wellness and prevention by linking HH enrollees with resources for tobacco cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences.				
Definition of Comprehensive Transitional Care	Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, Idaho Medicaid requires the designated provider to develop and utilize a process with hospitals and residential/rehabilitation facilities in their region to provide the HH care coordinator prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting. The designated provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers. The HH care coordinator will be an active participant in all phases of care transition.				
Definition of Individual and Family Support Services	Peer supports, support groups, and self-care programs will be utilized by the designated provider to increase patients' and caregivers knowledge of the individual's disease(s), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The designated provider will ensure that communication and information shared with the patient/patient's family is understandable.				
Definition of Referral to Community and Social Support Services	The designated provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. Designated providers will develop policies, procedures and accountabilities to support effective collaboration with community-based resources that clearly define the roles and responsibilities of the patients. They will also assist the participant in locating individual and family supports, including referral to community, social support, and recovery services.				

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Quality Measures	Goal based quality measures: • Improve care for diabetes among adults • Improve outcomes for individuals with mental illness • Increase preventive care for adults • Improve care for patients with heart disease • Improve care for asthma among adults and children • Increase preventive care for children See SPA for further details and calculations.				